We've got your training covered...

Worldwide

Dental Emergency Assistance Scheme

Scheme Guide

THE SCHEME

The Worldwide Dental Emergency Assistance Scheme - Details

The Worldwide Dental Emergency Assistance Scheme is a scheme established to offer support and assistance to Dental Plan patients who request treatment following a Dental Trauma and/or dental emergency or Oral Cancer. It is funded by your Dental Plan Administrator who makes payments to the Scheme to be held in a fund to be used to help patients who request assistance from the Scheme.

The Scheme is a wholly discretionary scheme, not an insured scheme. This means that it is at the sole and absolute discretion of the Scheme Manager as to whether benefits are paid. We ask that if at all possible, the patient contacts us first, in order to obtain pre-authorisation, before treatment commences or a request for assistance is submitted.

What is a wholly discretionary scheme and how is discretion applied?

Dental Plan patients are eligible to request assistance from the Scheme in the event of a Dental Trauma and/or dental emergency or Oral Cancer. The Scheme responds to such requests on a wholly discretionary basis. This means that, whilst the Scheme aims to provide Benefits in most cases, the Scheme has no obligation to provide any Benefit unless the Scheme Manager first decides (in its sole and absolute discretion) that the Scheme should provide a Benefit.

The Scheme Manager will look at each case individually to assess the request for a Benefit. It is possible that in some cases the Scheme Manager will decide to provide no Benefit. In addition, there are some circumstances in which the Scheme is not designed to help (these situations being similar to exclusions under an insurance policy), a summary is provided on Page 4. Full details can be found in the Scheme Handbook which details the Scheme Rules, Benefits, limitations and exclusions.

Contents

Requesting Assistance

In order for Requests for Assistance to be processed efficiently, please follow the steps below:

Pre-authorisation – all Benefit types

- Patient requests pre-authorisation by calling:
  a) During office hours, the Assistance Team, or
  b) Outside office hours, the Dental Helpline.

Your patient will be asked to provide the following:

- contact details, email address and telephone number
- any medical/dental concerns
- nature of incident – what, when, how and where

Where your patient also needs access to an emergency dentist, they will be asked to provide the following:

- current location, if away from home (postcode preferably)
- whether transport is available and distance prepared to travel to see a dentist
- any times unavailable to attend a practice.

- Pre-authorisation is granted.
- A Request for Assistance Form (RFA) can be requested direct from the Assistance Team or from the Registered Practice.
- An RFA is completed and signed by both Patient and Treating Dentist.
- The RFA is submitted to the Scheme Manager with any supporting documentation and the itemised receipt/invoice.
- The RFA is received and processed by the Assistance Team within five working days of receipt.
- The RFA is assessed against Scheme Rules and Benefit Schedules.

Processing – all benefit types

Dental Trauma

- **Authorisation** - Dependent on treatment plan content, the RFA may have to be referred to the Clinical Consultant for approval. Patient and practice are advised of outcome.
- **Treatment deferred** - At six months and three months prior to estimated completion date of treatment, we will request an update from the patient and the practice. If no response is received by the expected completion date, request will be closed. Patient and practice are advised of outcome.
- **Treatment completed** - Itemised invoice/receipts are submitted for reimbursement. The RFA is authorised and settled to the practice/patient as requested in the RFA. Patient and practice are advised of outcome.

REQUEST CLOSED.

OR

- **Treatment no longer required** - Letters sent to patient and practice confirming outcome.

REQUEST CLOSED.

Emergency Temporary Treatment and Callout Fees

- The RFA is authorised and settled with the practice/patient as requested in the RFA. Patient and practice are advised of outcome.

REQUEST CLOSED.

Oral Cancer/Hospitalisation/ Permanent Facial Disfigurement Requests

- Processed within five working days of receipt based on the correct supporting documentation being submitted with the RFA.

For queries about these types of requests, please call the Assistance Team on 0300 303 5061.

Redundancy

Following pre-authorisation, a RFA is issued direct to the patient.

Once authorised, patient is reimbursed monthly on receipt of their completed job search forms.

Payment - all request types

- Payments to settle requests are raised on a Tuesday and settled by BACS into the nominated account within five working days.

Invalid Requests - all request types

- A request for assistance may be declined during the pre-authorisation call, if it does not adhere to Scheme Rules.

- On receipt of a RFA, if the information provided conflicts with the pre-authorisation information, it may be declined.
- Patient and practice are advised of outcome.

REQUEST CLOSED.

Summary of Benefits

Worldwide Dental Emergency Assistance Scheme

This section is a summary only. Please see the Scheme Handbook for details of the Scheme Rules, Benefits, Limitations and Exclusions. Supplies of the Scheme Handbook are available from the Scheme Manager by calling 0300 303 5061 or by visiting scheme.wdeas.co.uk

Benefits

This Scheme provides benefits in the event of:

- **Dental Trauma**
- **Emergency Temporary Treatment, Telephone Consultation and Callout Fees**
- **Permanent Facial Disfigurement**
- **Hospitalisation**
- **Oral Cancer**
- **Redundancy (not included in the Registration Scheme, or if you are self-employed).**

DENTAL TRAUMA	
Benefits	• If you suffer dental trauma, the Scheme may (subject to certain limits) repay the cost of dental treatment provided by any dentist in respect of that dental trauma.
Limitations	• The amount paid will depend on the treatment. Your Scheme sets out the financial limits for each treatment (see Table of Benefits in Section 1 of your Scheme Handbook). • The maximum that the Scheme may pay is £10,000 for any one incident of dental trauma. • Prior authorisation must be obtained, where possible, before any treatment commences. • You may only make one request for a single course of treatment per incident of dental trauma. • For adults, treatment must be completed within two years of the date of the dental trauma. • For children, treatment of a dental injury must be completed within five years from the date of the dental trauma or when the child turns 18, whichever is the later.
Exclusions – What is not covered?	• A dental injury caused by a foodstuff (including foreign body in food or drink). • Minor tooth damage or normal wear and tear. • Damage to dentures (except if being worn at the time of the dental trauma). • Dental treatment previously prescribed, diagnosed or planned at the time of the dental trauma.

EMERGENCY TEMPORARY TREATMENT, TELEPHONE CONSULTATION AND CALLOUT FEES	
Benefits	• If you incur costs relating to emergency temporary treatment, a telephone consultation or callout fees in respect of pain relief or dental trauma, the Scheme may repay those costs (subject to certain limits).
Limitations	• The amount paid will depend on the treatment. Your Scheme sets out the financial limits for each treatment. • Emergency temporary treatment costs incurred outside the United Kingdom up to a limit of £475 per incident. • The maximum that the Scheme may pay is £950 per year..
Exclusions – What is not covered?	• A request for any incident which occurs when you are residing outside the United Kingdom for more than 180 consecutive days. • Treatment received during office working hours (8.00 am to 6.00 pm, Monday to Friday), provided by any of the following: - Your registered dentist - Another dentist at the same practice - A dental practice within a 15-mile radius of your registered practice. • Treatment received during the hours of 6.00 pm to 8.00 am Monday to Friday, Bank Holidays or Weekends, provided by your dentist, or another dentist at the same practice, where the practice is open for appointments. For example, a Saturday morning where your practice or dentist is open for general appointments. • Permanent treatment. Should permanent treatment be necessary, benefit may be paid at the equivalent temporary limit. • Any subsequent treatment required after the initial emergency appointment.

PERMANENT FACIAL DISFIGUREMENT	
Benefits	• The Scheme may pay a specified amount to you if you suffer permanent facial disfigurement as a result of dental trauma.
Limitations	• The amount paid is subject to financial limits and will depend on the extent of scarring (see Section 3 of your Scheme Handbook for details).
Exclusions – What is not covered?	• Scarring that is not visible 12 months from the date of the incident.

HOSPITALISATION	
Benefits	• The Scheme may pay an amount for each complete 24 hour period of hospitalisation if you are admitted as an in-patient as a direct result of dental trauma (see Section 4 of your Scheme Handbook for details).
Limitations	• The amount paid will pay is limited to a maximum of 365 days. • Where multiple injuries are sustained, we will only pay for the period of hospitalisation that relates directly to the dental trauma.
Exclusions – What is not covered?	• Subsequent hospitalisation in respect of the same dental trauma.

ORAL CANCER	
Benefits	• If you are diagnosed by an expert medical specialist as suffering from oral cancer as the primary site of the cancer, the Scheme may pay you £2,500.
Exclusions – What is not covered?	• Oral cancer which first manifests itself and/or is diagnosed within the first 90 days from the date you signed the Agreement or for which investigations or diagnosis have been made prior to joining the Dental Membership Plan. • Oral cancer directly or indirectly associated with Human Immunodeficiency Virus (HIV) or any related sickness including Acquired Immune Deficiency Syndrome (AIDS). • Benign or pre-malignant conditions, cancer in situ or other non-invasive conditions which are considered by your expert medical specialist to have no potential for spreading from one part of the body to another. • Oral cancer attributable to the smoking or chewing of tobacco products or betel nuts and/or alcohol abuse. • A recurrence of the same oral cancer, either at the same site or in a different location in the oral cavity.

REDUNDANCY	
Benefits	• The Scheme may pay your continuing Dental Membership Plan fees (and those of any dependants for whom you also pay the membership fee, subject to certain limits) if you are made redundant, for up to 12 months, provided that you can demonstrate that you are actively seeking employment.
Limitations	• Benefit will be payable for each complete 30 day period of total unemployment subject to a maximum fee payable for a single Dental Membership Plan of £15 per member per month for a single membership or a maximum of £60 per month for multiple Dental Membership Plan payments on behalf of you and your dependants. • You will only be entitled to make a further request for assistance under this Section if six months have elapsed since the last payment was made by us for a previous period of redundancy.
Exclusions – What is not covered?	• You have elected to join a Registration Scheme. • You are self-employed, or employed by a temporary employment agency. • Your unemployment ceases due to ill health. • You elect to take voluntary redundancy. • You have not been in continuous employment for the six months prior to the date of your redundancy.

GENERAL EXCLUSIONS	
These General Exclusions are applicable to all Sections of your Scheme Handbook. **You are not covered for:**	• Participation in rugby (other than rugby played as a school sport) or boxing, including training where you have not worn a suitable protective gum shield. • Participation in a criminal act; abuse of alcohol or drugs or an accident while under the influence of alcohol or drugs (unless such use is as prescribed by a doctor for a condition other than drug or alcohol addiction); or self-inflicted injuries. • Participation in war and/or similar military and other activities, or involvement in terrorism. • The effects of radiation. • Routine dental treatment costs, and costs recoverable from other insurance policies or schemes.

Completing a Request for Assistance Form

Dental Trauma - Injury or Accident

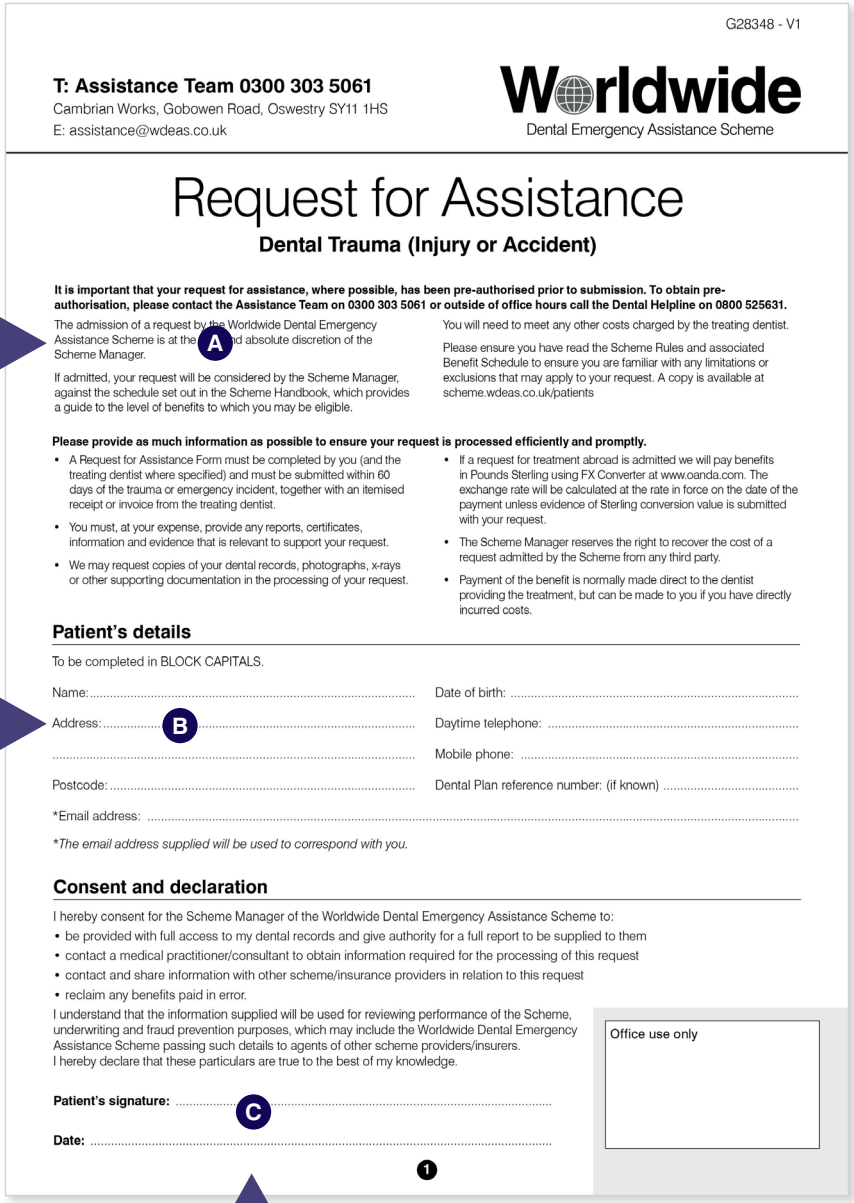
A. IMPORTANT INFORMATION

Please ensure you and your patient have read the Scheme Rules, associated Benefit Schedules and have read the declaration before completing this form.

B.PATIENT'S DETAILS

To be completed in full to ensure correct identification of your patient.

Where an email address has been provided, all correspondence in relation to the request will be via email to improve speed of communication with both patient and practice.



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T: Assistance Team 0300 303 5061
Cambrian Works, Gobowen Road, Oswestry SY11 1HS
E: assistance@wdeas.co.uk

Worldwide
Dental Emergency Assistance Scheme

Request for Assistance

Dental Trauma (Injury or Accident)

It is important that your request for assistance, where possible, has been pre-authorised prior to submission. To obtain pre-authorisation, please contact the Assistance Team on 0300 303 5061 or outside of office hours call the Dental Helpline on 0800 525631.

The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the [A] and absolute discretion of the Scheme Manager.

If admitted, your request will be considered by the Scheme Manager, against the schedule set out in the Scheme Handbook, which provides a guide to the level of benefits to which you may be eligible.

You will need to meet any other costs charged by the treating dentist.

Please ensure you have read the Scheme Rules and associated Benefit Schedule to ensure you are familiar with any limitations or exclusions that may apply to your request. A copy is available at scheme.wdeas.co.uk/patients

Please provide as much information as possible to ensure your request is processed efficiently and promptly.

- A Request for Assistance Form must be completed by you (and the treating dentist where specified) and must be submitted within 60 days of the trauma or emergency incident, together with an itemised receipt or invoice from the treating dentist.
- You must, at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
- We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
- If a request for treatment abroad is admitted we will pay benefits in Pounds Sterling using FX Converter at www.oanda.com. The exchange rate will be calculated at the rate in force on the date of the payment unless evidence of Sterling conversion value is submitted with your request.
- The Scheme Manager reserves the right to recover the cost of a request admitted by the Scheme from any third party.
- Payment of the benefit is normally made direct to the dentist providing the treatment, but can be made to you if you have directly incurred costs.

Patient's details

To be completed in BLOCK CAPITALS.

Name: ..... Date of birth: .....

Address: [B] ..... Daytime telephone: .....

..... Mobile phone: .....

Postcode: ..... Dental Plan reference number: (if known) .....

*Email address: .....

**The email address supplied will be used to correspond with you.*

Consent and declaration

I hereby consent for the Scheme Manager of the Worldwide Dental Emergency Assistance Scheme to:

- be provided with full access to my dental records and give authority for a full report to be supplied to them
- contact a medical practitioner/consultant to obtain information required for the processing of this request
- contact and share information with other scheme/insurance providers in relation to this request
- reclaim any benefits paid in error.

I understand that the information supplied will be used for reviewing performance of the Scheme, underwriting and fraud prevention purposes, which may include the Worldwide Dental Emergency Assistance Scheme passing such details to agents of other scheme providers/insurers.
I hereby declare that these particulars are true to the best of my knowledge.

Office use only

Patient's signature: ..... [C] .....

Date: .....

1

C. CONSENT AND DECLARATION

Without the patient's signature, we are unable to fully process the request. The patient must read the declaration and sign to show they have understood it before submitting the Request for Assistance Form.

Once pre-authorisation has been granted, to enable the efficient processing of any request for assistance, please ensure the form is completed in full before returning to the Scheme Manager, with any necessary supporting documentation.

Please refer to the following pages for further instructions on how to complete these forms.

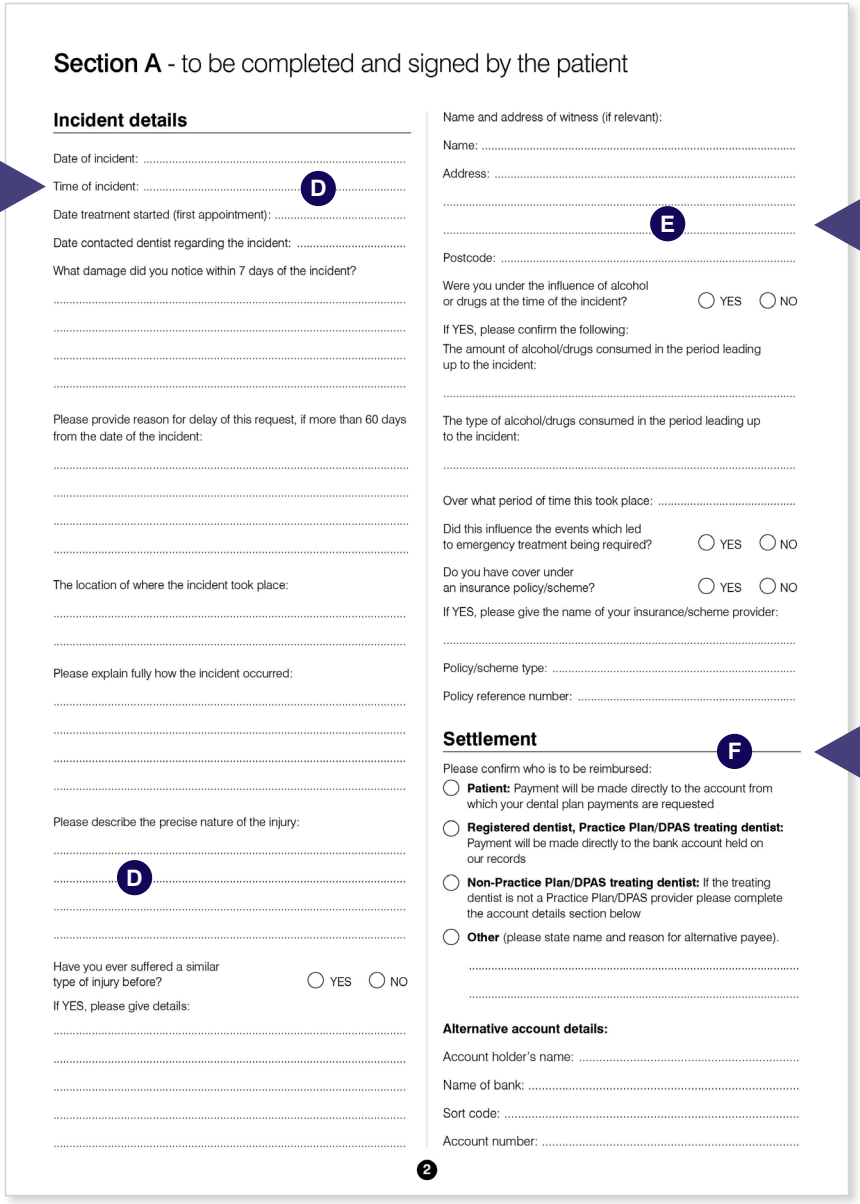
For redundancy requests, following pre-authorisation, a Request for Assistance Form will be issued direct to the patient.

D. INCIDENT DETAILS

In this section the patient is asked about the event that caused damage to their teeth. If the patient has any further information that they wish to provide, we are happy to accept supporting documentation.

The information provided must be detailed and accurate as it will determine the outcome of the request.

Where a request is received more than 60 days from date of occurrence, please ensure an explanation for the delay is submitted with the Request for Assistance Form.



Section A - to be completed and signed by the patient

Incident details

Date of incident: .....

Time of incident: ..... D .....

Date treatment started (first appointment): .....

Date contacted dentist regarding the incident: .....

What damage did you notice within 7 days of the incident?

.....

.....

.....

.....

Please provide reason for delay of this request, if more than 60 days from the date of the incident:

.....

.....

.....

.....

The location of where the incident took place:

.....

.....

Please explain fully how the incident occurred:

.....

.....

.....

.....

Please describe the precise nature of the injury:

.....

..... D .....

.....

.....

Have you ever suffered a similar type of injury before? ◯ YES ◯ NO

If YES, please give details:

.....

.....

.....

.....

.....

Name and address of witness (if relevant):

Name: .....

Address: .....

.....

..... E .....

Postcode: .....

Were you under the influence of alcohol or drugs at the time of the incident? ◯ YES ◯ NO

If YES, please confirm the following:

The amount of alcohol/drugs consumed in the period leading up to the incident:

.....

The type of alcohol/drugs consumed in the period leading up to the incident:

.....

Over what period of time this took place: .....

Did this influence the events which led to emergency treatment being required? ◯ YES ◯ NO

Do you have cover under an insurance policy/scheme? ◯ YES ◯ NO

If YES, please give the name of your insurance/scheme provider:

.....

Policy/scheme type: .....

Policy reference number: .....

Settlement F

Please confirm who is to be reimbursed:

◯ **Patient:** Payment will be made directly to the account from which your dental plan payments are requested

◯ **Registered dentist, Practice Plan/DPAS treating dentist:** Payment will be made directly to the bank account held on our records

◯ **Non-Practice Plan/DPAS treating dentist:** If the treating dentist is not a Practice Plan/DPAS provider please complete the account details section below

◯ **Other** (please state name and reason for alternative payee).

.....

.....

Alternative account details:

Account holder's name: .....

Name of bank: .....

Sort code: .....

Account number: .....

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E. WITNESS, INFLUENCING FACTORS AND OTHER INSURANCE/ SCHEME COVER

In this section the patient is asked about any factors that may have had an influence on the incident or if they have other insurance/scheme cover in place that may be used to contribute towards the treatment costs.

F. SETTLEMENT

When the request has been approved and treatment has been completed, we can either reimburse the patient on receipt of an itemised receipt or pay the practice on receipt of an itemised invoice.

However, if the patient would like us to reimburse to an alternative account, they can provide the information in the request form.

Settlement is via BACS into the nominated bank account.

Completing a Request for Assistance Form

Dental Trauma - Injury or Accident - continued

G. TREATING AND REGISTERED DENTIST'S DETAILS

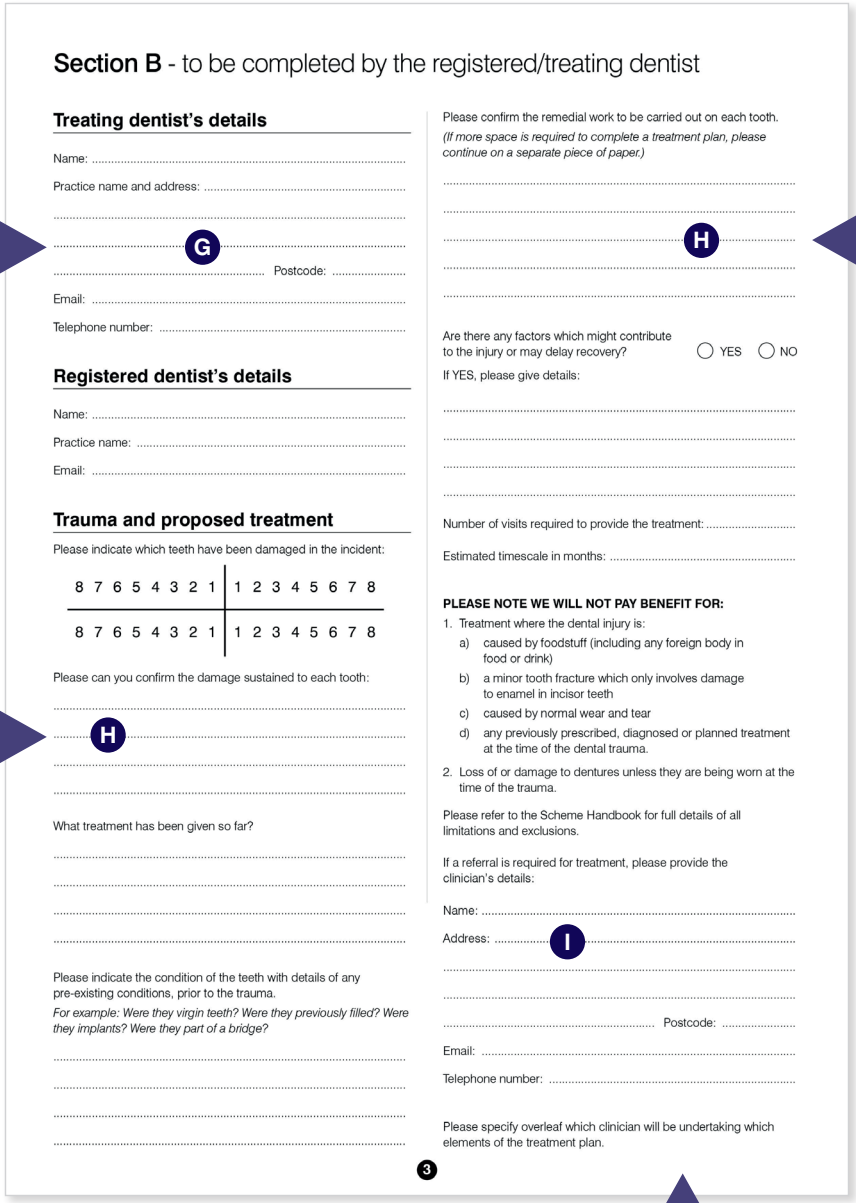
In many cases it is the patient's own registered dentist that the patient is seeing, but on occasion someone else will assess and provide the restorative treatment. No matter who provides the treatment, we need the dentist's information in order to contact them regarding any questions about the proposed treatment and to inform them of our decision.

H. TRAUMA AND PROPOSED TREATMENT

It is essential that we know the teeth involved in the trauma and the full extent of the damage that has occurred, including their condition at the time of the trauma.

Detail any teeth that were not directly impacted by the trauma but where treatment is being provided as part of the whole treatment plan.

These will show as a shortfall, so that the patient is aware of all costs involved in the treatment plan.



Section B - to be completed by the registered/treating dentist

Treating dentist's details

Name: .....

Practice name and address: .....

.....

..... G .....

..... Postcode: .....

Email: .....

Telephone number: .....

Registered dentist's details

Name: .....

Practice name: .....

Email: .....

Trauma and proposed treatment

Please indicate which teeth have been damaged in the incident:

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Please can you confirm the damage sustained to each tooth:

.....

..... H .....

.....

.....

What treatment has been given so far?

.....

.....

.....

.....

Please indicate the condition of the teeth with details of any pre-existing conditions, prior to the trauma.

For example: Were they virgin teeth? Were they previously filled? Were they implants? Were they part of a bridge?

.....

.....

.....

.....

Please confirm the remedial work to be carried out on each tooth.

(If more space is required to complete a treatment plan, please continue on a separate piece of paper.)

.....

.....

..... H .....

.....

.....

Are there any factors which might contribute to the injury or may delay recovery? ◯ YES ◯ NO

If YES, please give details:

.....

.....

.....

.....

Number of visits required to provide the treatment: .....

Estimated timescale in months: .....

PLEASE NOTE WE WILL NOT PAY BENEFIT FOR:

1. Treatment where the dental injury is:
   a) caused by foodstuff (including any foreign body in food or drink)
   b) a minor tooth fracture which only involves damage to enamel in incisor teeth
   c) caused by normal wear and tear
   d) any previously prescribed, diagnosed or planned treatment at the time of the dental trauma.
2. Loss of or damage to dentures unless they are being worn at the time of the trauma.

Please refer to the Scheme Handbook for full details of all limitations and exclusions.

If a referral is required for treatment, please provide the clinician's details:

Name: .....

Address: ..... I .....

.....

.....

..... Postcode: .....

Email: .....

Telephone number: .....

Please specify overleaf which clinician will be undertaking which elements of the treatment plan.

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H. CONTINUED...

Please provide details of the treatment plan(s) that have been agreed with the patient and estimated timescales.

Please remember a request is only valid for two years from date of the incident for an adult and five years or 18 years of age (whichever is latest) for a child.

Internal trauma is no longer covered under the Scheme. However, if emergency treatment has been provided, a request may be valid – please see the Scheme Handbook for full details and the Emergency Request for Assistance Form on page 10 of this guide.

I. REFERRED DENTIST

We understand that not all of the treatment can be provided by the same dentist. In cases where treatment has been referred to another dentist, please provide their details.

Notes:

J. TREATMENT PLAN

To ensure that a request is authorised correctly, it is essential that this section is completed in full.

Where you are proposing multiple scenarios, please indicate to which plan the treatment is allocated.

If the patient is entitled to discounts under their plan membership then the discounts should be applied where appropriate.

Treatment plan

Please indicate in the table below the full cost of the treatment. Please note that incomplete treatment plans may result in a delay in authorisation to you and the patient. This treatment plan will be provided to the patient upon approval. **Please note**, where the patient is entitled to receive discount on treatments, ensure the correct discounted amount is entered in the Dentist Charge column.

Treatment	Quantity	Tooth Notation	Dentist Charge	Office Use Only	Indicate if emergency treatment
Examination	Per Incident				
X-rays	Upto 2 per Incident				
Non-Surgical Extraction	Per Tooth				
Surgical Extraction	Per Tooth				
Filling - Small (build up only)	1 Surface				
Filling - Medium (build up only)	2 Surfaces				
Filling - Large (build up only)	3 + Surfaces				
Root Canal Therapy - Molar (to incl sealing canal)	Per Tooth				
Root Canal Therapy - Canine/Incisor (to incl sealing canal)	Per Tooth				
Root Canal Therapy - Pre-Molar (to incl sealing canal)	Per Tooth				
All Ceramic Crown*	Per Tooth				
Porcelain Bonded Crown*	Per Tooth				
Full Precious Metal Crown*	Per Tooth				
Porcelain Jacket Crown*	Per Tooth				
Dentine Bonded Crown (incl core/post)	Per Tooth				
Laboratory Made Post and Core	Per Tooth				
Post and Core (dentine)	Per Tooth				
Adhesive Bridge*	Per Pontic				
Adhesive Bridge*	Per Retainer				
Porcelain Bonded or Precious Metal Bridgework (Pontic)*	Per Pontic				
Porcelain Bonded or Precious Metal Bridgework (Retainer)*	Per Retainer				
Bridgework all metal*	Per Pontic				
Bridgework all metal*	Per Retainer				
Permanent Full Acrylic Denture	Per Denture				
Permanent Partial Acrylic Denture	Per Denture				
Permanent Cobalt/Chrome Denture	Per Denture				
Porcelain Veneer*	Per Tooth				
Temporary Denture (Following Tooth Loss)	Per Denture				
Temporary Bridge (Following Tooth Loss)	Per Unit				
Implants - Single Tooth*	Per Unit				
Addition to a Denture	Per Tooth				
Re-cement Bridge	Per Bridge				
Re-cement Crown/Veneer (re-cement only)	Per Tooth				
Other Necessary Treatment - Please list (including emergency attention where required)	Per Incident				
		TOTAL			

*Treatment includes the fixture of prostheses (including all laboratory costs) and all surgery including second stage surgery

Fees for prosthetic work are inclusive of laboratory fees and any temporary covering. Prosthetic work includes crowns, veneers, implants, inlays, onlays, and all types of bridges and dentures, either full or partial.

Please note that you may only be reimbursed up to the individual maximum limits for the treatments and to the benefit limit (€10,000) as shown on your Benefit Schedule. You will need to meet any other costs charged.

Please note the time limits applicable to all requests for assistance: For adults, treatment must be completed within two years of the date of the dental trauma. For children, treatment of a dental injury must be completed within five years of the date of the dental trauma, or when the child turns 18, whichever is the later.

CHECKLIST : BEFORE YOU SUBMIT THIS FORM, PLEASE CHECK

- Has it been signed, by dentist and patient where applicable?
- Has a treatment plan, itemised invoice, receipt or statement of account been included?
- Has every section been completed?

Declaration

I hereby declare that the information provided is accurate to the best of my knowledge and costs and quantities detailed in the Treatment Plan reflect any discounts related to the patient's Dental Plan.

Dentist's signature: ..... K .....

Date: .....

4

J. CONTINUED...

Where initial emergency treatment has been provided, please indicate in column 6.

K. DECLARATION

It is important that the dentist signs the treatment plan. Without the signature, we will not know if the treatment is a true representation of the dentist's intentions.

ADMISSION OF A REQUEST

When a request has been approved and settled, the patient is informed of our decision and will receive a full breakdown of the benefits being applied.

Checklist

- Have you verified the request against the Scheme Rules and Benefit Schedules?
- Have you completed all the sections?
- Have both the dentist and the patient signed?
- Have you included an itemised invoice or receipt for reimbursement?

Failure to complete the form in full or submit all the required documents could lead to unnecessary processing delays.

Completing a Request for Assistance Form

Emergency Temporary Treatment, Telephone Consultation and Callout Fees

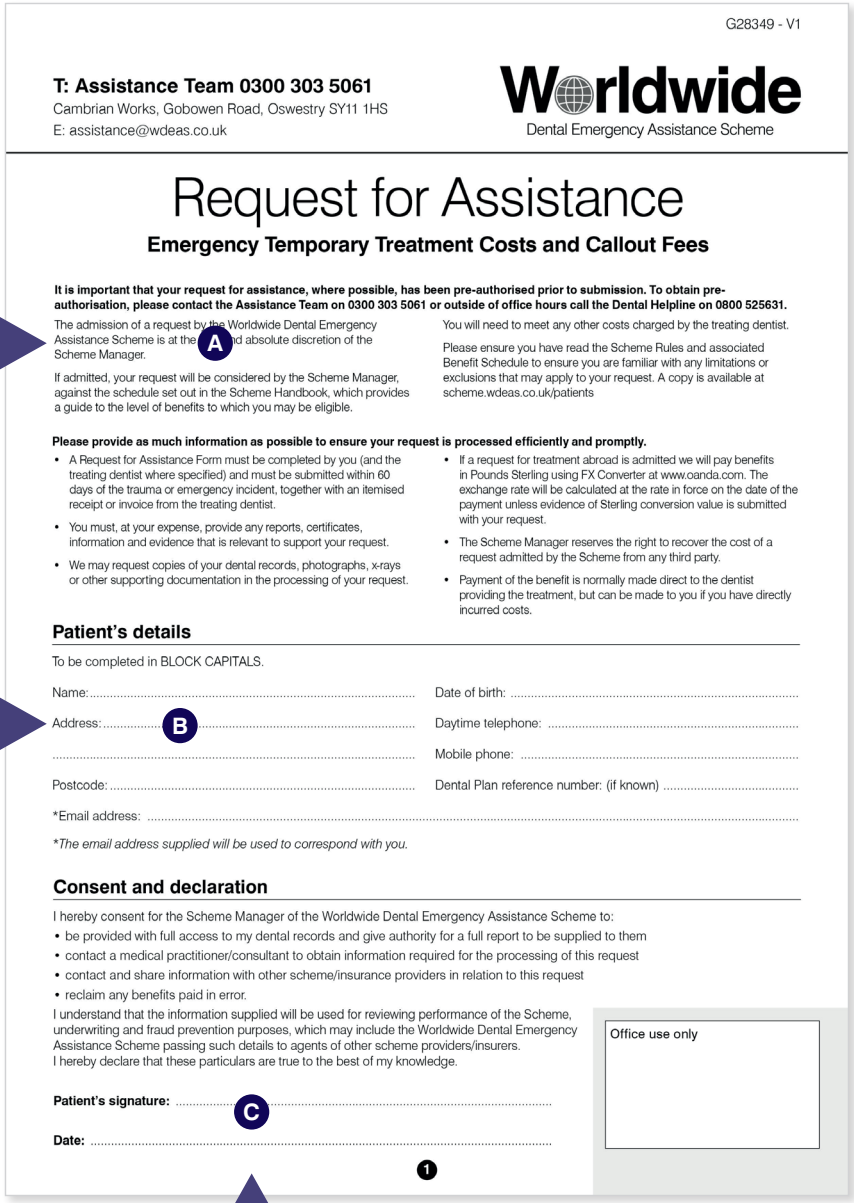
A. IMPORTANT INFORMATION

Please ensure you and your patient have read the Scheme Rules, associated Benefit Schedules and have read the declaration before completing this form.

B.PATIENT'S DETAILS

To be completed in full to ensure correct identification of your patient.

Where an email address has been provided, all correspondence in relation to the request will be via email to improve speed of communication with both patient and practice.



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T: Assistance Team 0300 303 5061
Cambrian Works, Gobowen Road, Oswestry SY11 1HS
E: assistance@wdeas.co.uk

Worldwide
Dental Emergency Assistance Scheme

Request for Assistance

Emergency Temporary Treatment Costs and Callout Fees

It is important that your request for assistance, where possible, has been pre-authorised prior to submission. To obtain pre-authorisation, please contact the Assistance Team on 0300 303 5061 or outside of office hours call the Dental Helpline on 0800 525631.

The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the [A] and absolute discretion of the Scheme Manager.

If admitted, your request will be considered by the Scheme Manager, against the schedule set out in the Scheme Handbook, which provides a guide to the level of benefits to which you may be eligible.

You will need to meet any other costs charged by the treating dentist.

Please ensure you have read the Scheme Rules and associated Benefit Schedule to ensure you are familiar with any limitations or exclusions that may apply to your request. A copy is available at scheme.wdeas.co.uk/patients

Please provide as much information as possible to ensure your request is processed efficiently and promptly.

- A Request for Assistance Form must be completed by you (and the treating dentist where specified) and must be submitted within 60 days of the trauma or emergency incident, together with an itemised receipt or invoice from the treating dentist.
- You must, at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
- We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
- If a request for treatment abroad is admitted we will pay benefits in Pounds Sterling using FX Converter at www.oanda.com. The exchange rate will be calculated at the rate in force on the date of the payment unless evidence of Sterling conversion value is submitted with your request.
- The Scheme Manager reserves the right to recover the cost of a request admitted by the Scheme from any third party.
- Payment of the benefit is normally made direct to the dentist providing the treatment, but can be made to you if you have directly incurred costs.

Patient's details

To be completed in BLOCK CAPITALS.

Name: ..... Date of birth: .....

Address: [B] ..... Daytime telephone: .....

..... Mobile phone: .....

Postcode: ..... Dental Plan reference number: (if known) .....

*Email address: .....

**The email address supplied will be used to correspond with you.*

Consent and declaration

I hereby consent for the Scheme Manager of the Worldwide Dental Emergency Assistance Scheme to:
- be provided with full access to my dental records and give authority for a full report to be supplied to them
- contact a medical practitioner/consultant to obtain information required for the processing of this request
- contact and share information with other scheme/insurance providers in relation to this request
- reclaim any benefits paid in error.

I understand that the information supplied will be used for reviewing performance of the Scheme, underwriting and fraud prevention purposes, which may include the Worldwide Dental Emergency Assistance Scheme passing such details to agents of other scheme providers/insurers.
I hereby declare that these particulars are true to the best of my knowledge.

Office use only

Patient's signature: ..... [C] .....

Date: .....

1

C. CONSENT AND DECLARATION

Without the patient's signature, we are unable to fully process the request. The patient must read the declaration and sign to show they have understood it before submitting the Request for Assistance Form.

Once pre-authorisation has been granted, to enable the efficient processing of any request for assistance, please ensure the form is completed in full before returning to the Scheme Manager, with any necessary supporting documentation.

Please refer to the following pages for further instructions on how to complete these forms.

For redundancy requests, following pre-authorisation, a Request for Assistance Form will be issued direct to the patient.

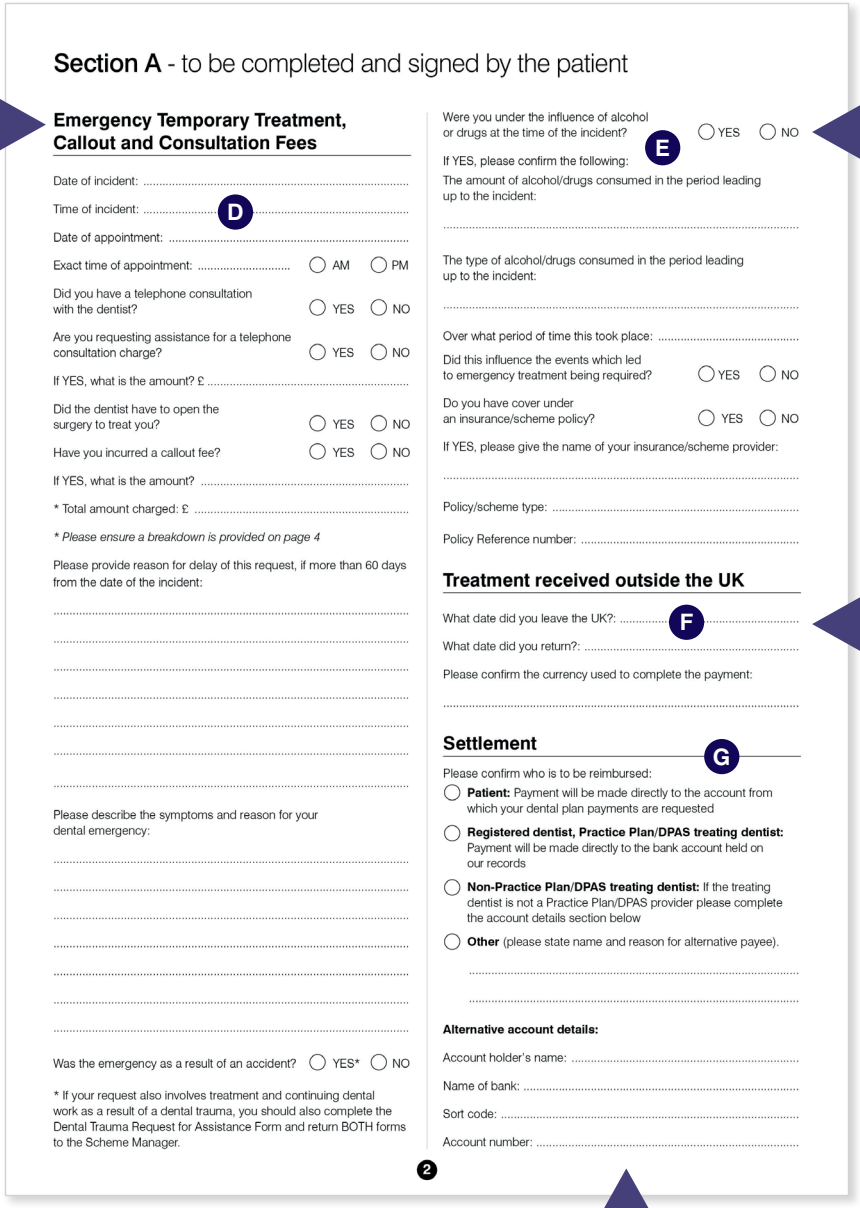
D. INCIDENT DETAILS

In this section the patient is asked about the details of the emergency appointment. If the patient has any further information that they wish to provide, we are happy to accept any supporting documentation.

We ask when a patient had their appointment so that we can apply the correct benefits and check eligibility.

The information provided must be detailed and accurate as it will determine the outcome of the request.

Where a request is received more than 60 days from date of occurrence, please ensure an explanation for the delay is submitted with the Request for Assistance Form.



Section A - to be completed and signed by the patient

Emergency Temporary Treatment, Callout and Consultation Fees

Date of incident: .....

Time of incident: ..... **D** .....

Date of appointment: .....

Exact time of appointment: ..... ◯ AM ◯ PM

Did you have a telephone consultation with the dentist? ◯ YES ◯ NO

Are you requesting assistance for a telephone consultation charge? ◯ YES ◯ NO

If YES, what is the amount? £ .....

Did the dentist have to open the surgery to treat you? ◯ YES ◯ NO

Have you incurred a callout fee? ◯ YES ◯ NO

If YES, what is the amount? .....

* Total amount charged: £ .....

** Please ensure a breakdown is provided on page 4*

Please provide reason for delay of this request, if more than 60 days from the date of the incident:

.....

.....

.....

.....

.....

.....

.....

Please describe the symptoms and reason for your dental emergency:

.....

.....

.....

.....

.....

.....

.....

Was the emergency as a result of an accident? ◯ YES* ◯ NO

* If your request also involves treatment and continuing dental work as a result of a dental trauma, you should also complete the Dental Trauma Request for Assistance Form and return BOTH forms to the Scheme Manager.

Were you under the influence of alcohol or drugs at the time of the incident? ◯ YES ◯ NO

If YES, please confirm the following: **E**

The amount of alcohol/drugs consumed in the period leading up to the incident:

.....

The type of alcohol/drugs consumed in the period leading up to the incident:

.....

Over what period of time this took place: .....

Did this influence the events which led to emergency treatment being required? ◯ YES ◯ NO

Do you have cover under an insurance/scheme policy? ◯ YES ◯ NO

If YES, please give the name of your insurance/scheme provider:

.....

Policy/scheme type: .....

Policy Reference number: .....

Treatment received outside the UK

What date did you leave the UK?: ..... **F** .....

What date did you return?: .....

Please confirm the currency used to complete the payment:

.....

Settlement **G**

Please confirm who is to be reimbursed:

◯ **Patient:** Payment will be made directly to the account from which your dental plan payments are requested

◯ **Registered dentist, Practice Plan/DPAS treating dentist:** Payment will be made directly to the bank account held on our records

◯ **Non-Practice Plan/DPAS treating dentist:** If the treating dentist is not a Practice Plan/DPAS provider please complete the account details section below

◯ **Other** (please state name and reason for alternative payee).

.....

.....

Alternative account details:

Account holder's name: .....

Name of bank: .....

Sort code: .....

Account number: .....

2

E. INFLUENCING FACTORS AND OTHER INSURANCE/ SCHEME COVER

In this section the patient is asked about any factors that may have had an influence on the incident or if they have other insurance/scheme cover in place that may be used to contribute towards the treatment costs.

F. TREATMENT RECEIVED OUTSIDE THE UK

The Scheme does not cover incidents that occur when a patient is residing outside the United Kingdom for more than 180 consecutive days, so it is important that we know when the patient left the UK.

Proof of Sterling equivalent is acceptable in the form of itemised receipts, or bank/credit card statements.

G. SETTLEMENT

When the request has been approved for payment, we can either reimburse the patient or practice, providing we have received an itemised invoice or receipt. However, if the patient would like us to reimburse to an alternative account, they can provide the information in the request form.

Settlement is via BACS into the nominated bank account.

Completing a Request for Assistance Form

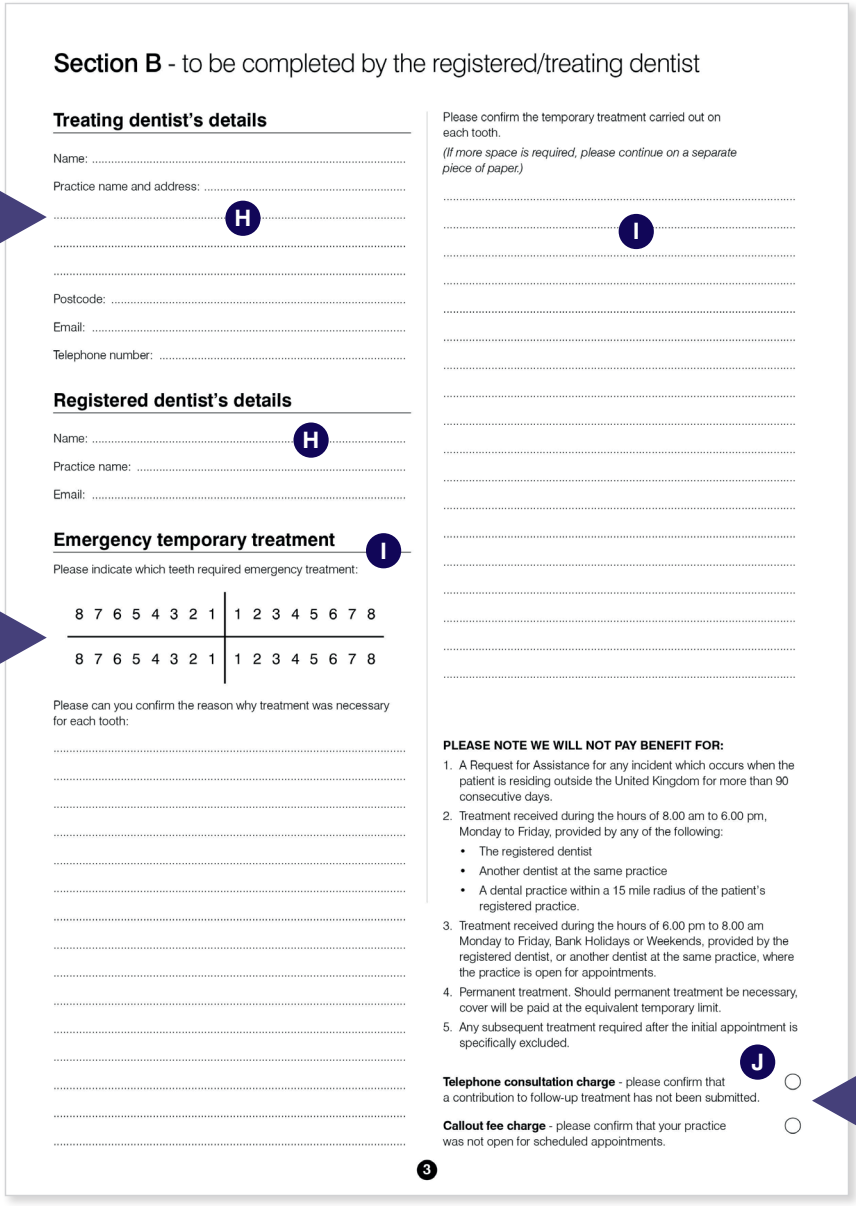
Emergency Temporary Treatment, Telephone Consultation and Callout Fees - continued

H. TREATING AND REGISTERED DENTIST'S DETAILS

In many cases it is the patient's own registered dentist that the patient is seeing, but on occasion someone else will assess and provide the temporary treatment. No matter who provides the treatment, we need the dentist's information in order to contact them regarding any questions about the request and for HMRC purposes.

I. EMERGENCY TEMPORARY TREATMENT

It is essential that we know which teeth required emergency treatment, why and what temporary treatment has been provided.



Section B - to be completed by the registered/treating dentist

Treating dentist's details

Name: .....

Practice name and address: .....

H

.....

.....

Postcode: .....

Email: .....

Telephone number: .....

Registered dentist's details

Name: ..... H

Practice name: .....

Email: .....

Emergency temporary treatment I

Please indicate which teeth required emergency treatment:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Please can you confirm the reason why treatment was necessary for each tooth:

.....

Please confirm the temporary treatment carried out on each tooth.

(If more space is required, please continue on a separate piece of paper.)

I

PLEASE NOTE WE WILL NOT PAY BENEFIT FOR:

1. A Request for Assistance for any incident which occurs when the patient is residing outside the United Kingdom for more than 90 consecutive days.
2. Treatment received during the hours of 8.00 am to 6.00 pm, Monday to Friday, provided by any of the following:
   - The registered dentist
   - Another dentist at the same practice
   - A dental practice within a 15 mile radius of the patient's registered practice.
3. Treatment received during the hours of 6.00 pm to 8.00 am Monday to Friday, Bank Holidays or Weekends, provided by the registered dentist, or another dentist at the same practice, where the practice is open for appointments.
4. Permanent treatment. Should permanent treatment be necessary, cover will be paid at the equivalent temporary limit.
5. Any subsequent treatment required after the initial appointment is specifically excluded.

J

Telephone consultation charge - please confirm that a contribution to follow-up treatment has not been submitted. ○

Callout fee charge - please confirm that your practice was not open for scheduled appointments. ○

3

J. TELEPHONE CONSULTATION/ CALLOUT FEE CHARGES

Where an RFA has been submitted for Telephone Consultancy or Callout fees, you will need to confirm that further RFAs will or have not been submitted.

Notes:

K. BREAKDOWN OF EMERGENCY TEMPORARY TREATMENT, TELEPHONE CONSULTATION AND CALLOUT COSTS

To ensure that a request is authorised and settled appropriately, it is essential that this section is completed in full.

If permanent restorative treatment is provided, benefits will be based on the temporary equivalent.

If the patient is entitled to discounts under their plan membership then the discounts should be applied where appropriate.

Breakdown of Callout Fee and Emergency Temporary Treatment

	Units	Tooth Notation	Dentist Charge	Office Use Only
Emergency Callout Fee				
Weekdays - 6am-8am, 6pm-10pm	Per Incident			
Weekdays & weekends - 10pm-6am	Per Incident	K		
Weekends & bank holidays - 6am-10pm	Per Incident			
Telephone Consultation				
Telephone Consultation (where no follow-up appointment has occurred)	Per Incident			
Emergency Temporary Treatment Costs	**Your request is subject to an overall benefit cap, please see handbook for details.**			
Examination	Per Incident			
X-rays	Per Incident			
Treatment to stop haemorrhage	Per Incident			
Tooth extraction (max two teeth)	Per Tooth			
Root extirpation - 1 canal	Per Tooth			
Root extirpation - 2 canals	Per Tooth			
Root extirpation - 3+ canals	Per Tooth			
Treatment of infection	Per Incident			
Investigation - 1st tooth	Per Tooth			
Investigation - additional teeth	Per Tooth			
Resecure crown or inlay	Per Tooth			
Resecure bridge	Per Bridge			
Temporary bridge	Per Bridge			
Temporary crown	Per Tooth			
Temporary post and core	Per Tooth			
Repair/adjust orthodontic appliance	Per Appliance			
Repair of denture	Per Denture			
Adjust denture	Per Denture			
Remove sutures	Per Incident			
Other Emergency Temporary Treatment (please list)	Per Incident			
Emergency – International (Inclusive of callout & treatment)	Per Incident			
			TOTAL	

Please note that you may only be reimbursed up to individual maximum limits for the treatments (as shown on the Benefit Schedule) subject to an overal benefit limit per request, and an annual limit. Please see current Scheme Handbook for details of benefits, limits and exclusions which is available to download from **scheme.wdeas.co.uk/patients**. You will need to meet any other costs charged.

CHECKLIST : BEFORE YOU SUBMIT THIS FORM, PLEASE CHECK

- Has it been signed, by dentist and patient where applicable?
- Has a treatment plan, itemised invoice, receipt or statement of account been included?
- Has every section been completed?

Declaration

I hereby declare that the information provided is accurate to the best of my knowledge and costs and quantities detailed in the Treatment Plan reflect any discounts related to the patient's Dental Plan.

Dentist's signature: ..... L .....

Date: .....

4

K. CONTINUED...

If the patient has suffered a trauma, please ensure a Dental Trauma Request for Assistance Form is completed and submitted as soon as possible.

ADMISSION OF A REQUEST

When a request has been approved and settled, the patient is informed of our decision and will receive a full breakdown of the benefits being applied.

L. DECLARATION

It is important that the dentist signs the treatment plan. Without the signature, we will not know if the treatment is a true representation of the dentist's intentions.

Checklist

- Have you verified the request against the Scheme Rules and Benefit Schedules?
- Have you completed all the sections?
- Have both the dentist and the patient signed?
- Have you included an itemised invoice or receipt for reimbursement?

Failure to complete the form in full or submit all the required documents could lead to unnecessary processing delays.

Completing a Request for Assistance Form

Hospitalisation, Permanent Facial Disfigurement, and Oral Cancer

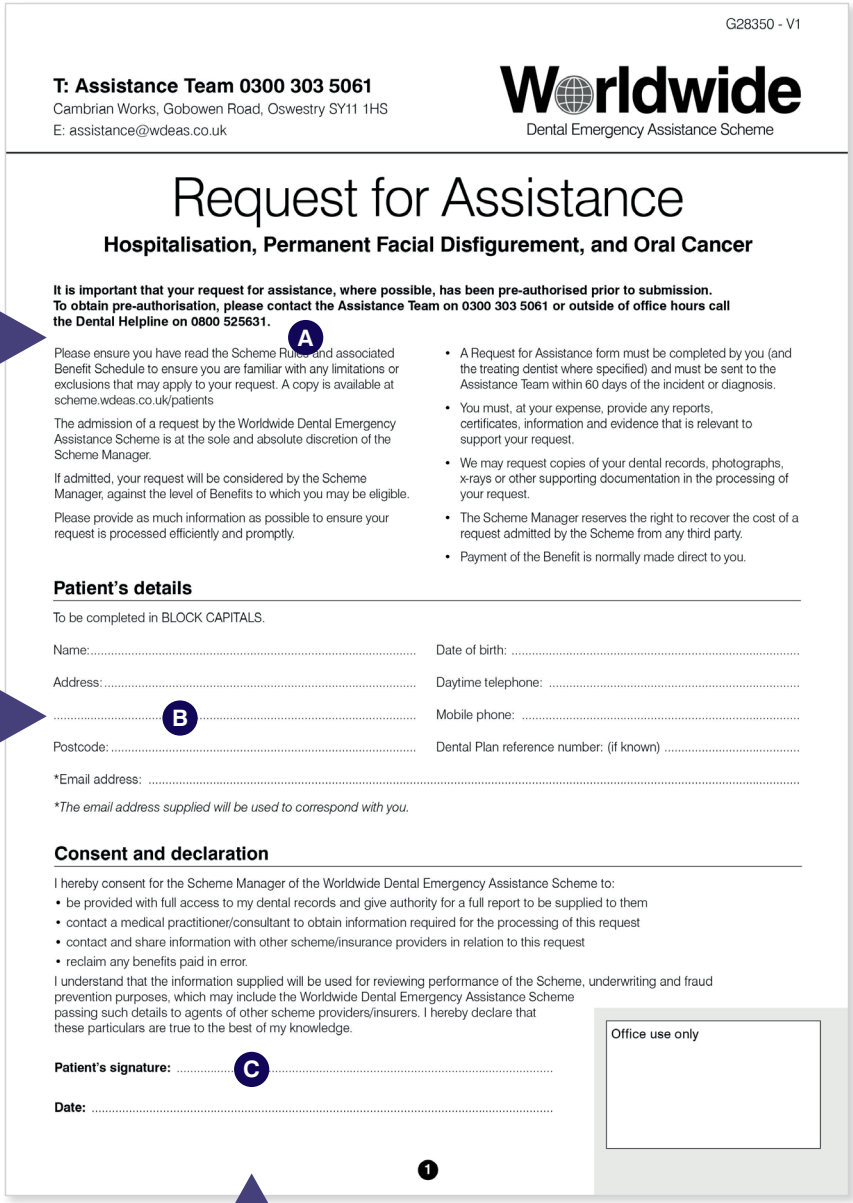
A. IMPORTANT INFORMATION

Please ensure you and your patient have read the Scheme Rules, associated Benefit Schedules and have read the declaration before completing this form.

B.PATIENT'S DETAILS

To be completed in full to ensure correct identification of your patient.

Where an email address has been provided, all correspondence in relation to the request will be via email to improve speed of communication with both patient and practice.



G28350 - V1

T: Assistance Team 0300 303 5061
Cambrian Works, Gobowen Road, Oswestry SY11 1HS
E: assistance@wdeas.co.uk

Worldwide
Dental Emergency Assistance Scheme

Request for Assistance

Hospitalisation, Permanent Facial Disfigurement, and Oral Cancer

It is important that your request for assistance, where possible, has been pre-authorised prior to submission. To obtain pre-authorisation, please contact the Assistance Team on 0300 303 5061 or outside of office hours call the Dental Helpline on 0800 525631.

A

Please ensure you have read the Scheme Rules and associated Benefit Schedule to ensure you are familiar with any limitations or exclusions that may apply to your request. A copy is available at scheme.wdeas.co.uk/patients

The admission of a request by the Worldwide Dental Emergency Assistance Scheme is at the sole and absolute discretion of the Scheme Manager.

If admitted, your request will be considered by the Scheme Manager, against the level of Benefits to which you may be eligible.

Please provide as much information as possible to ensure your request is processed efficiently and promptly.

- A Request for Assistance form must be completed by you (and the treating dentist where specified) and must be sent to the Assistance Team within 60 days of the incident or diagnosis.
- You must, at your expense, provide any reports, certificates, information and evidence that is relevant to support your request.
- We may request copies of your dental records, photographs, x-rays or other supporting documentation in the processing of your request.
- The Scheme Manager reserves the right to recover the cost of a request admitted by the Scheme from any third party.
- Payment of the Benefit is normally made direct to you.

Patient's details

To be completed in BLOCK CAPITALS.

Name:..... Date of birth: .....

Address:..... Daytime telephone: .....

..... B ..... Mobile phone: .....

Postcode:..... Dental Plan reference number: (if known) .....

*Email address: .....

**The email address supplied will be used to correspond with you.*

Consent and declaration

I hereby consent for the Scheme Manager of the Worldwide Dental Emergency Assistance Scheme to:

- be provided with full access to my dental records and give authority for a full report to be supplied to them
- contact a medical practitioner/consultant to obtain information required for the processing of this request
- contact and share information with other scheme/insurance providers in relation to this request
- reclaim any benefits paid in error.

I understand that the information supplied will be used for reviewing performance of the Scheme, underwriting and fraud prevention purposes, which may include the Worldwide Dental Emergency Assistance Scheme passing such details to agents of other scheme providers/insurers. I hereby declare that these particulars are true to the best of my knowledge.

Patient's signature: ..... C .....

Date: .....

Office use only

1

C. CONSENT AND DECLARATION

Without the patient's signature, we are unable to fully process the request. The patient must read the declaration and sign to show they have understood it before submitting the Request for Assistance Form.

Once pre-authorisation has been granted, to enable the efficient processing of any request for assistance, please ensure the form is completed in full before returning to the Scheme Manager, with any necessary supporting documentation.

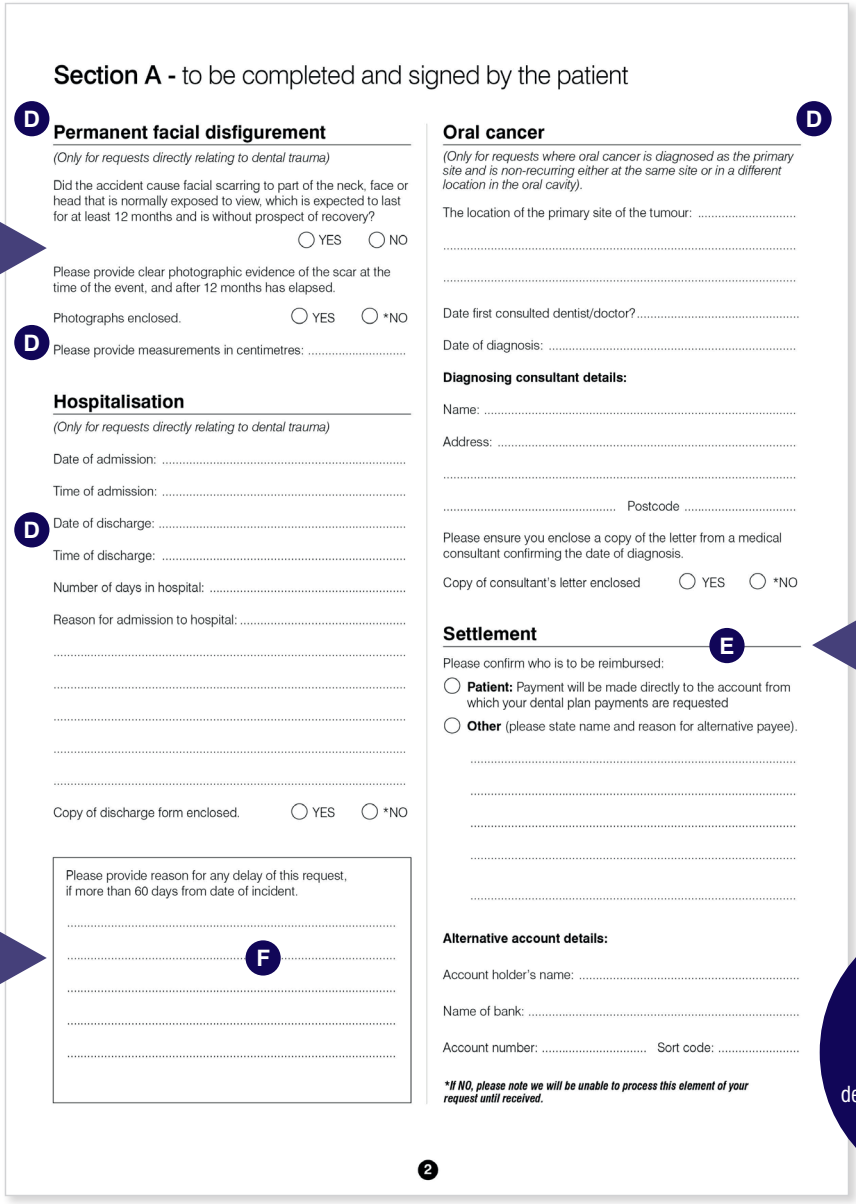
Please refer to the following pages for further instructions on how to complete these forms.

For redundancy requests, following pre-authorisation, a Request for Assistance Form will be issued direct to the patient.

D. SECTION A

Please complete the appropriate section depending on the request type.

Ensuring that the appropriate supporting documents are submitted, will avoid any delays for the patient. Use the tick boxes as a checklist.



Section A - to be completed and signed by the patient

D

Permanent facial disfigurement

(Only for requests directly relating to dental trauma)

Did the accident cause facial scarring to part of the neck, face or head that is normally exposed to view, which is expected to last for at least 12 months and is without prospect of recovery?

◯ YES ◯ NO

Please provide clear photographic evidence of the scar at the time of the event, and after 12 months has elapsed.

Photographs enclosed. ◯ YES ◯ *NO

D

Please provide measurements in centimetres: .....

Hospitalisation

(Only for requests directly relating to dental trauma)

Date of admission: .....

Time of admission: .....

D

Date of discharge: .....

Time of discharge: .....

Number of days in hospital: .....

Reason for admission to hospital: .....

.....

.....

.....

.....

.....

Copy of discharge form enclosed. ◯ YES ◯ *NO

Please provide reason for any delay of this request, if more than 60 days from date of incident.

.....

.....

F

.....

.....

.....

D

Oral cancer

(Only for requests where oral cancer is diagnosed as the primary site and is non-recurring either at the same site or in a different location in the oral cavity).

The location of the primary site of the tumour: .....

.....

.....

Date first consulted dentist/doctor? .....

Date of diagnosis: .....

Diagnosing consultant details:

Name: .....

Address: .....

.....

..... Postcode .....

Please ensure you enclose a copy of the letter from a medical consultant confirming the date of diagnosis.

Copy of consultant's letter enclosed ◯ YES ◯ *NO

Settlement

E

Please confirm who is to be reimbursed:

◯ **Patient:** Payment will be made directly to the account from which your dental plan payments are requested

◯ **Other** (please state name and reason for alternative payee).

.....

.....

.....

.....

.....

Alternative account details:

Account holder's name: .....

Name of bank: .....

Account number: ..... Sort code: .....

If NO, please note we will be unable to process this element of your request until received.

2

E. SETTLEMENT

When the request has been approved for payment, we will make the payment to the patient. However, if the patient would like us to pay to an alternative account, they can provide the information in the request form.

Settlement is via BACS into the nominated bank account.

F. LATE SUBMISSION OF AN RFA

Where a request is received more than 60 days from date of occurrence, please ensure an explanation for the delay is submitted with the Request for Assistance Form.

ADMISSION OF A REQUEST

When a request has been approved and settled, the patient is informed of our decision and will receive a full breakdown of the benefits being applied.

Checklist

- Have you verified the request against the Scheme Rules and Benefit Schedules?
- Have you completed all the sections?
- Have both the dentist and the patient signed the form?
- Have you included supporting documentation:
  - Photographs for a permanent facial disfigurement request?
  - A letter of diagnosis from the consultant for an oral cancer request?
  - A discharge letter for a hospitalisation request?

Failure to complete the form in full or submit all the required documents could lead to unnecessary processing delays.

Contact us

Assistance Team: 0300 303 5061
For all your queries relating to the Scheme or submitting a Request for Assistance.

Registered address:
Assistance Team, WDEAS, Cambrian Works
Gobowen Road, Oswestry, Shropshire SY11 1HS

Email: assistance@wdeas.co.uk

Web: scheme.wdeas.co.uk

Dental Helpline (UK): 0808 169 8117
Outside UK working hours (9.00 am - 5.00 pm)

Dental Helpline (if overseas): (0044) 1691 887955

For general enquiries relating to your dental plan, please contact your plan provider:

Practice Plan Limited:
Tel: 01691 684120
Email: info@practiceplan.co.uk
Web: www.practiceplan.co.uk

DPAS Limited:
Tel: 01747 870910
Email: info@dpas.co.uk
Web: www.dpas.co.uk

Calls to the above numbers may be recorded for training and monitoring purposes.

THE SCHEME

G28405 V1.0